Department of Medical Assistance Services
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Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Providers Billing on the CMS-1450 (UB-04) Form

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 2/21/2007

SUBJECT: General Billing Instructions for the New CMS-1450 (UB-04) - Effective April 1, 2007

The purpose of this memorandum is to provide you with the Department of Medical Assistance Services' (DMAS) general billing instructions for the new CMS-1450 (UB-04). This new form allows for the accommodation of the National Provider Identifier (NPI) as well as current provider identifiers for the transition period. This new form will replace the current CMS-1450 (UB-92) form for claims submitted on or after May 23, 2007. DMAS will allow the submission of the new UB-04 beginning with claims received on or after April 1, 2007.

The instructions within this memo are for all providers enrolled in Virginia Medicaid that currently utilize the CMS-1450 form. Some providers will have more detailed and specific requirements for their unique business needs that will be addressed in an upcoming provider manual billing chapter update. A separate memo to those providers affected will be released with their manual updates.

DMAS has followed the National Uniform Billing Committee (NUBC) requirements for the new form with a few exceptions which will be addressed later in this memo. The NUBC has established standards in the formatting of this form to facilitate the use of image processing technology such as Optical Character Recognition (OCR) and image storage. For specific printing standards information, refer to the NUBC Instruction Manual for UB-04 from the NUBC website at www.nubc.org.

Billing Specifics for All Providers:

Printing:

- The CMS-1450 (UB-04) form is to be red OCR "dropout" ink or the exact match. There should be no contamination with "black or blue" ink.
- The font must not be smaller than 10-pitch Pica type, 6 lines per inch vertical and 10 characters per inch horizontal.

- All printing of this form must occur in accordance with the NUBC requirements.
- DMAS will not reprocess claims that are denied as a result of errors consequential to the claim form not complying with these NUBC standards.

Timeline:

- On April 1, 2007, DMAS will begin accepting the CMS-1450 (UB-04).
- On May 23, 2007, the CMS-1450 (UB-04) is mandated to be used for any claims received on or after this date. DMAS will also be required to accept only the NPI on the form.

General Billing Requirements Specific to the CMS-1450 (UB-04):

- Locator 30: This locator will be used to indicate that you are billing DMAS for Medicare Crossover deductible or coinsurance amounts. The word 'CROSSOVER' is to be entered.

- Locator 37: This locator will be used to indicate that you are billing a Temporary Detention Order (TDO) or an Emergency Custody Order (ECO) claim. You will enter either 'TDO' or 'ECO' to indicate the appropriate order being billed.

- Locator 39: In this area, the number of covered or non-covered days will be entered using the correct value code. See specifics contained in the complete billing instructions.

- Locator 56: National Provider Identifier (NPI) **– Enter your NPI. Once DMAS is in the dual use period effective on March 26, 2007, providers will submit their NPI in this locator on the UB-04. Until further notice, providers should enter their legacy Medicaid number in locator 57.**

- Locator 57A: Other Provider Identifier – Enter your legacy Medicaid provider number in this locator until DMAS is accepting NPI for claims processing, effective March 26, 2007. Effective May 23, 2007, DMAS will not accept claims received with the legacy Medicaid number in this locator. Enter the provider number on the appropriate line that corresponds to the recipient name in locator 50.

- Locator 63: Treatment Authorization Code – Enter the 11-digit preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid. Note: The 15-digit TDO or ECO order number from the pre-printed form is to be entered in this locator.

ELIGIBILTY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is **http://virginia.fhsc.com**. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at **www.dmas.virginia.gov**. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manuals updates that are requested.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at **www.dmas.virginia.gov/pr-provider_newletter.asp**.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

INSTRUCTIONS FOR COMPLETING THE UB-04 CMS-1450 CLAIM FORM:
DMAS will allow the use of this claim form beginning with claims received on or after April 1, 2007 but is mandatory for claims received on or after May 23, 2007.

Locator		Instructions
1	**Provider Name, Address, Telephone Required**	**Provider Name, Address, Telephone** - Enter the provider's name, complete mailing address and telephone number of the provider that is submitting the bill and which payment is to be sent. Line 1. Provider Name Line 2. Street Address Line 3. City. State, and Zip Code Line 4. Telephone; Fax; Country Code
2	**Pay to Name & Address Required if Applicable**	**Pay to Name & Address** - Enter the address of the provider where payment is to be sent, if different than Locator 1. NOTE: DMAS will need to have the 9 digit zip code on line three, left justified for adjudicating the claim if the provider has provided only one NPI and the servicing provider has multiple site locations for this service.
3a	**Patient Control Number Required**	**Patient Control Number** – Enter the patient's unique financial account number which does not exceed 20 alphanumeric characters.
3b	**Medical/Health Record Required**	**Medical/Health Record** - Enter the number assigned to the patient's medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.
4	**Type of Bill Required**	**Type of Bill** - Enter the code as appropriate. Valid codes for Virginia Medicaid are: 0111 Original Inpatient Hospital Invoice 0112 Interim Inpatient Hospital Claim Form* 0113 Continuing Inpatient Hospital Claim Invoice* 0114 Last Inpatient Hospital Claim Invoice* 0117 Adjustment Inpatient Hospital Invoice 0118 Void Inpatient Hospital Invoice 0131 Original Outpatient Invoice 0137 Adjustment Outpatient Invoice 0138 Void Outpatient Invoice These below are for Medicare Crossover Claims Only 0721 Clinic – Hospital Based or Independent Renal Dialysis Center

Locator		Instructions
		0717 Clinic – Adjustment-Hospital Based or Independent Renal Dialysis Center 0718 Clinic – Void – Hospital Based or Independent Renal Dialysis Center * The proper use of these codes (see the National UB-04 Manual) will enable DMAS to reassemble inpatient acute medical/surgical hospital cycle-billed claims to form DRG cases for purposes of DRG payment calculations and cost settlement.
5	Federal Tax Number Not Required	Federal Tax Number – The number assigned by the federal government for tax reporting purposes
6	**Statement Covered Period Required**	**Statement Covered Period -** Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day. For hospital admissions, the billing cycle for general medical surgical services has been expanded to a minimum of 120 days for both children and adults except for psychiatric services. Psychiatric services for adults' remains limited to the 21 days. Interim claims (bill types 112 or 113) submitted with less than 120 day will be denied. Bill type 111 or 114 submitted with greater than 120 days will be denied.
7	Reserved for assignment by the NUBC	Reserved for assignment by the NUBC **NOTE: This locator on the UB 92 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.**
8	**Patient Name/Identifier Required**	**Patient Name/Identifier** - Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.
9	Patient Address	Patient Address – Enter the mailing address of the patient. a. Street address b. City c. State d. Zip Code (9 digits) e. Country Code if other than USA
10	**Patient Birthdate Required**	**Patient Birthdate** – Enter the date of birth of the patient.
11	**Patient Sex Required**	**Patient Sex** – Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male; F = female and U =

Locator		Instructions
		unknown
12	**Admission/Start of Care Required**	**Admission/Start of Care –** The start date for this episode of care. For inpatient services, this is the date of admission. For all other services, the date the episode of care began.
13	**Admission Hour Required**	**Admission Hour -** Enter the hour during which the patient was admitted for inpatient or outpatient care. **Note**: Military time is used as defined by NUBC.
14	**Priority (Type) of Visit Required**	**Priority (Type) of Visit –** Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS are: **Code** — **Description** 1 — Emergency- patient requires immediate intervention for severe, life threatening or potentially disabling condition 2 — Urgent – patient requires immediate attention for the care and treatment of physical or mental disorder 3 — Elective – patient's condition permits adequate time to schedule the services 5 — Trauma – Visit to a licensed or designated by the state or local government trauma center/hospital and involving a trauma activation 9 — Information not available
15	**Source of Referral for Admission or Visit Required**	**Source of Referral for Admission or Visit -** Enter the code indicating the source of the referral for this admission or visit. **Note:** Appropriate codes accepted by DMAS are: **Code:** — **Description** 1 — Physician Referral 2 — Clinic Referral 4 — Transfer from Another Acute Care Facility 5 — Transfer from a Skilled Nursing Facility 6 — Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility 7 — Emergency Room 8 — Court/Law Enforcement- Admitted Under Direction of a Court of Law, or Under Request of Law Enforcement Agency 9 — Information not available D — Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer
16	**Discharge Hour Required**	**Discharge Hour** – Enter the code indicating the discharge hour of the patient from inpatient care. **Note:** Military time is used as defined by NUBC

Locator		Instructions
17	**Patient Discharge Status Required**	**Patient Discharge Status –** Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (statement covered period, locator 6). Note: If the patient was a one-day stay, enter code "01". Appropriate codes accepted by DMAS are:

Code	Description
01	Discharged to Home
02	Discharged/transferred to Short term General Hospital for Inpatient Care
03	Discharged/transferred to Skilled Nursing Facility
04	Discharged/transferred to Intermediate Care Facility
05	Discharged/transferred to Another Facility not Defined Elsewhere
07	Left Against Medical Advice or Discontinued Care
20	Expired
30	Still a Patient
50	Hospice – Home
51	Hospice – Medical Care Facility
61	Discharged/transferred to Hospital Based Medicare Approved Swing Bed
62	Discharged/transferred to an Inpatient Rehabilitation Facility
63	Discharged/transferred to a Medicare Certified Long Term Care Hospital
64	Discharged/transferred to Nursing Facility Certified under Medicaid but not Medicare
65	Discharged/transferred to Psychiatric Hospital of Psychiatric Distinct Part Unit of Hospital

18 thru 28	**Condition Codes Required if applicable**	**Condition Codes** – Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication. **Note**: DMAS limits the number of condition codes to maximum of 8 on one claim. These codes are used by DMAS in the adjudication of claims:

Code	Description
39	Private Room Medically Necessary
40	Same Day Transfer
A1	EPSDT
A4	Family Planning
A5	Disability
A7	Inducted Abortion Danger to Life
AA	Abortion Performed due to Rape
AB	Abortion Performed due to Incest
AD	Abortion Performed due to a Life Endangering Physical Condition
AH	Elective Abortion
AI	Sterilization

29	**Accident State**	**Accident State** – Enter if known the state (two digit state abbreviation) where the accident occurred.
30	**Crossover Part**	**Note:** DMAS is requiring for Medicare Part A crossover claims that

Locator		Instructions
	A Indicator	the word **"CROSSOVER"** be in this locator
31 thru 34	**Occurrence Code and Dates Required if applicable**	**Occurrence Code and Dates –** Enter the code and associated date defining a significant event relating to this bill. Enter codes in alphanumeric sequence.
35 thru 36	**Occurrence Span Code and Dates Required if applicable**	**Occurrence Span Code and Dates –** Enter the code and related dates that identify an event that relates to the payment of the claim. Enter codes in alphanumeric sequence.
37	**TDO or ECO Indicator Required if applicable**	**Note:** DMAS is requiring that for claims to be processed by the Temporary Detention Order (TDO) or by Emergency Custody Order (ECO) program, providers will enter TDO or ECO in this locator.
38	Responsible Party Name and Address	Responsible Party Name and Address – Enter the name and address of the party responsible for the bill
39 thru 41	**Value codes and Amount Required**	**Value Codes and Amount -** Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim. **Note:** DMAS will be capturing the number of covered or non-covered day(s) or units for inpatient and outpatient service(s) with these required value codes: 80 Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims. 81 Enter the number of non-covered days for inpatient hospitalization **AND** One of the following codes **must** be used to indicate the coordination of third party insurance carrier benefits: 82 No Other Coverage 83 Billed and Paid (enter amount paid by primary carrier) 85 Billed Not Covered/No Payment For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above: A1 Deductible from Part A A2 Coinsurance from Part A Other codes may also be used if applicable. The a, b, or c line containing this above information should Cross Reference to Payer Name (Medicaid or TDO) in Locator 50 A, B, C.

Locator		Instructions
42	**Revenue Code Required**	**Revenue Codes** - Enter the appropriate revenue code(s) for the service provided. Note: • Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order, • Multiple services for the same item, providers should aggregate the service under the assigned revenue code and then the total number of units that represents those services, • DMAS has a limit of five pages for one claim, • The Total Charge revenue code (0001) should be the last line of the last page of the claim • See the Revenue Codes list under "Exhibits" at the end of your current provider manual for approved DMAS codes.
43	**Revenue Description Required**	**Revenue Description -** Enter the standard abbreviated description of the related revenue code categories included on this bill.
44	**HCPCS/Rates/ HIPPS Rate Codes Required (if applicable)**	**HCPCS/Rates/HIPPS Rate Codes -** Inpatient: Enter the accommodation rate. Outpatient: Enter the applicable HCPCS code. For Ambulatory Surgical Centers, enter the CPT or HCPCS code on the same line that the revenue code 0490 is entered.
45	**Service Date Required if applicable**	**Service Date -** Enter the date the outpatient service was provided.
46	**Service Units Required**	**Service Units -** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit).
47	**Total Charges Required**	**Total Charges -** Enter the total charge(s) for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non covered charges. **Note:** Use code "0001" for TOTAL.
48	**Non-Covered Charges Required if applicable**	**Non-Covered Charges –** To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.
49	Reserved	Reserved for Assignment by the NUBC.
50	**Payer Name A-C. Required**	**Payer Name** – Enter the payer from which the provider may expect some payment for the bill. A Enter the primary payer identification. B Enter the secondary payer identification, if applicable.

Locator		Instructions
		C Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C. This also applies to the Temporary Detention and Emergency Custody Order claims.
51	Health Plan Identification Number A-C	Health Plan Identification Number - The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill. **NOTE:** DMAS will no longer use this locator to capture the Medicaid provider number. Refer to locators 56 and 57
52	Release of Information Certification Indicator A-C	Release of Information Certification Indicator - Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.
53	Assignment of Benefits Certification Indicator A-C	Assignment of Benefits Certification Indicator - Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.
54	**Prior Payments – Payer A,B,C Required (if applicable)**	**Prior Payments Payer** – Enter the amount the provider has received (to date) by the health plan toward payment of this bill. **NOTE:** Long-Term Hospitals and Nursing Facilities: Enter the patient pay amount on the appropriate line (a-c) that is showing Medicaid as the payer in locator 50. The amount of the patient pay is shown on the DMAS-122 Form furnished by the Local Department of Social Services Office. Note: A=Primary B=Secondary C=Tertiary **<u>DO NOT ENTER THE MEDICAID COPAY AMOUNT</u>**
55	Estimated Amount Due A,B,C,	Estimated Amount Due – Payer – Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).
56	**NPI Required**	**National Provider Identifier** – Enter your NPI. Once DMAS is in the dual use period, effective March 26, 2007 through May 22, 2007, providers will submit their NPI in this locator on the UB 04. Until providers are ready to use their NPI (but no earlier than March 26, 2007) they should enter their legacy Medicaid number in locator 57.
57A	**Other Provider**	**Other Provider Identifier** – Enter your legacy Medicaid provider

Locator		Instructions
thru C	**Identifier Required (if applicable)**	number in this locator until DMAS is accepting NPI for claims processing (dual use begins March 26, 2007). Effective May 23, 2007, DMAS will not accept claims received with the legacy Medicaid number in this locator. Enter the provider number on the appropriate line that corresponds to the recipient name in locator 50.
58	**Insured's Name A-C Required**	**INSURED'S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. • Enter the insured's name used by the primary payer identified on Line A, Locator 50. • Enter the insured's name used by the secondary payer identified on Line B, Locator 50. • Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**Patient's Relationship to Insured A-C Required**	**Patient's Relationship to Insured** - Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are: **Code:** / **Description:** 01 Spouse 18 Self 19 Child 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner G8 Other Relationship
60	**Insured's Unique Identification A-C Required**	**Insured's Unique Identification** - For lines A-C, enter the unique identification number of the person insured that is assigned by the payer organization shown on Lines A-C, Locator 50. **NOTE:** The Medicaid recipient identification number is 12 numeric digits.
61	(Insured) Group Name A-C	(Insured) Group Name - Enter the name of the group or plan through which the insurance is provided.
62	Insurance Group Number A-C	Insurance Group Number - Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.
63	**Treatment Authorization Code Required (if**	**Treatment Authorization Code** - Enter the 11 digits preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid. **Note:** The 15 digit TDO or ECO order number from the pre-printed

Locator		Instructions
	applicable)	form is to be entered in this locator.
64	**Document Control Number** (DCN) **Required for adjustment and void claims**	**Document Control Number** – The control number assigned to the original bill by Virginia Medicaid as part of their internal claims reference number. **Note:** This locator is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim.
65	Employer Name (of the Insured) A-C	Employer Name (of the Insured) - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**Diagnosis and Procedure Code Qualifier Required**	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator) –** The qualifier that denotes the version of the International Classification of Diseases. Qualifier = 9 for Ninth Revision. **Note:** DMAS will only accept a 9 in this locator.
67	**Principal Diagnosis Code Required**	**Principal Diagnosis Code -** Enter the ICD-9-CM diagnosis code that describes the principal diagnosis (i.e., the condition established after study which is chiefly responsible for occasioning the admission of the patient for care). NOTE: Special instructions for the Present on Admission indicator below. **DO NOT USE DECIMALS.**
67 & 67A-Q	**Present on Admission (POA) Indicator Required**	**Present on Admission (POA) Indicator** – The eighth digit of the Principal, Other Diagnosis and External Cause of Injury Codes are to be indicated if: • the diagnosis was known at the time of admission, or • the diagnosis was clearly present, but not diagnosed, until after admission took place or • was a condition that developed during an outpatient encounter. The POA indicator is in the shaded area. Reporting codes are: Code: Definition: Y Yes N No U No information in the record W Clinically undetermined
67 A thru Q	**Other Diagnosis Codes Required if applicable**	**Other Diagnosis Codes** Enter the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. **DO NOT USE DECIMALS.**

Locator		Instructions
68	**Special Note**	**Note:** Facilities may place the adjustment or void error reason code in this locator. If nothing here, DMAS will default to error codes: 1052 – miscellaneous void or 1053 – miscellaneous adjustment.
69	**Admitting Diagnosis Required**	**Admitting Diagnosis –** Enter the diagnosis code describing the patient's diagnosis at the time of admission. **DO NOT USE DECIMALS.**
70 a-c	**Patient's Reason for Visit Required if applicable**	**Patient's Reason for Visit –** Enter the diagnosis code describing the patient's reason for visit at the time of inpatient or unscheduled outpatient registration**.** **DO NOT USE DECIMALS.**
71	Prospective Payment System (PPS) Code	Prospective Payment System **–** Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72	**External Cause of Injury Required if applicable**	**External Cause of Injury** - Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. **DO NOT USE DECIMALS.**
73	Reserved	Reserved for Assignment by the NUBC
74	**Principal Procedure Code and Date Required if applicable**	**Principal Procedure Code and Date –** Enter the ICD-9-CM procedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date. **Note:** For outpatient claims, a procedure code must appear in this locator when revenue codes 0360-0369, 0420-0429, 0430-0439, and 0440-0449 (if covered by Medicaid) are used in Locator 42 or the claim will be rejected. For inpatient claims, a procedure code or one of the diagnosis codes of V64.1 through V64.3 must appear in this locator (or locator 67) when revenue codes 0360-0369 are used in locator 42 or the claim will be rejected. For revenue codes other than those identified above used in Locator 42, the claims will not be rejected due to the lack of a procedure code in this locator. Procedure code 8905 will be used by Virginia Medicaid if the locator is left blank. Procedures that are done in the Emergency Room (ER) one day prior to the recipient being admitted for an inpatient hospitalization **from** the ER must be included on the inpatient claim. **DO NOT USE DECIMALS**
74a-e	**Other Procedure**	**Other Procedure Codes and Date –** Enter the ICD-9-CM

Locator		Instructions
	Codes and Date Required if applicable	procedure codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. **DO NOT USE DECIMALS.**
75	Reserved	Reserved for assignment by the NUBC
76	**Attending Provider Name and Identifiers Required**	**Attending Provider Name and Identifiers** - Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Inpatient: Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. Once the dual use is implemented, effective March 26, 2007, the NPI may be entered in the "NPI" space. After May 22, 2007, only the attending physicians' NPI will be accepted in the "NPI" space. Outpatient: Enter the 9-digit number assigned by Medicaid for the physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI, on and after 3/26/2007 if the provider has given DMAS their NPI. Once the dual use is implemented, effective March 26, 2007, the NPI may be entered in the "NPI" space. After May 22, 2007, only the physicians' NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is '82' (Rendering Provider) whenever the legacy Medicaid number is entered. **Note:** If the NPI is in locator 56, then this locator must also have the attending providers NPI.
77	**Operating Physician Name and Identifiers Required if applicable**	**Operating Physician Name and Identifiers** – Enter the name and the 9-digit number assigned by Medicaid of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim. Inpatient: Enter the 9-digit number assigned by Medicaid for the operating physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. Once the dual use is implemented, effective March 26, 2007, the NPI may be entered in the "NPI" space. After May 22, 2007, only the operating physicians' NPI will be accepted in the "NPI" space. Outpatient: Enter the 9-digit number assigned by Medicaid for the operating physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. Once the dual use is implemented, effective March 26, 2007, the NPI may be entered in the "NPI" space. After May 22, 2007, only the physicians' NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is either '82' (Rendering Provider), 'DN' (Referring Provider) or 'ZZ' (Other Operating

Locator		Instructions
		Physician) whenever the legacy Medicaid number is entered.
78 - 79	**Other Provider Name and Identifiers Required if applicable**	**Other Physician ID.** - Enter the 9 digit provider number assigned by Medicaid for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit. This is required for all MEDALLION patients. For MEDALLION patients referred to an outpatient clinic, enter the 9 digit provider ID number assigned by Medicaid for the PCP who authorized the outpatient visit. For Client Medical Management (CMM) patients referred to the emergency room by the PCP, enter the 9 digit provider ID number and attach the Practitioner Referral Form (DMAS-70). Non-emergency Emergency Room visits will be paid at a reduced rate. Enter the 9 digit PCP provider number for all inpatient stays. For Hospice Providers: If revenue code 0658 is billed, then enter the nursing facility provider number in this locator. Please refer below to the time frame for entrance of either the legacy Medicaid provider number or the NPI. **Note:** Once the dual use is implemented, the NPI may be entered in the "NPI" space. After May 22, 2007, only the physician's NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is 'DN' (Referring Provider) whenever the legacy Medicaid number is entered.
80	**Remarks Field**	**Remarks Field** – Enter additional information necessary to adjudicate the claim. Enter a brief description of the reason for the submission of the adjustment or void. If there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Provide other information necessary to adjudicate the claim.
81	**Code-Code Field Required if applicable**	**Code-Code Field** – Enter the provider taxonomy code for the billing provider when the adjudication of the claim is known to be impacted. DMAS will be using this field to capture taxonomy for claims that are submitted with one NPI with multiple business types or locations (eg, Rehabilitative or Psychiatric units within an acute care facility; Home Health Agency with multiple locations). **Code B3 is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.**

Note: Hospitals with **one** NPI must use a taxonomy code when submitting claims for different business types.

Service Type Description	Taxonomy Code(s)
Hospital, General	282N00000X
Rehabilitation Unit of Hospital	273Y00000X
Psychiatric Unit of Hospital	273R00000X
Private Mental Hospital (inpatient)	283Q00000X
Rehabilitation Hospital	283X00000X
Psychiatric Residential Inpatient Facility	323P00000X – Psychiatric Residential Treatment Facility
Transportation – Emergency Air or Ground Ambulance	3416A0800X – Air Transport 3416L0300X – Land Emergency Transport

If you have a question related to Taxonomy, please e-mail DMAS at NPI@dmas.virginia.gov.

Forward the original with any attachments for consideration of payment to:

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7444

Maintain the Institution copy in the provider files for future reference.

UB-04 (CMS-1450) Adjustment and void invoices

- To **adjust** a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges.
  - Type of Bill (Locator 4) - Enter code 117 for inpatient hospital services or enter code 137 for outpatient services.
  - Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.
  - Locator 68 – Enter the four digit adjustment reason code (refer to the below listing for codes acceptable by DMAS.
  - Remarks (Locator 80) - Enter an explanation for the adjustment.

NOTE: Inpatient claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim.

- Admission Date
- From or Through Date
- Discharge Status
- Diagnosis Code(s)
- Procedure Code(s)

Acceptable Adjustment Codes:

Code	Description
1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment
1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/ service code
1029	Correcting diagnosis code
1030	Correcting charge
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

- To **void** a previously paid claim, complete the following data elements on the UB-04 CMS-1450:

- Type of Bill (Locator 4) – Enter code 118 for inpatient hospital services or enter code 138 for outpatient hospital services.

- Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.

- Locator 68 – Enter the four digit void reason code (refer to the below listing for codes acceptable by DMAS.

- Remarks (Locator 80) – Enter an explanation for the adjustment.

Acceptable Void Codes:

Code	Description
1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available